



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

To Whom It May Concern:

I, Amy R. Smith, hereby acknowledge that I am receiving (or am about to receive) health care services at Western Street Clinic. I have been advised that the doctor providing the services is willing to wait for payment for these services, provided that there continues to be a reasonable chance that payment will be made either by insurance proceeds or out of the settlement of a liability claim.

I understand and agree to pay for services rendered on a current basis if it is determined that:

- 1) there is no insurance company obligated to pay for these services
- 2) the insurance company involved refuses to acknowledge an assignment to the doctor or make other provisions for the protection of the interest of the doctor
- 3) a liability claim exists, but my attorney refuses to agree to protect the interest of the doctor
- 4) I have not engaged the services of an attorney

Also, I understand and agree to pay my bill in full as soon as my liability claim is settled or within three months of my last treatment, whichever occurs first.

Dated the _____ day of _____, _____
(day of month) (month) (year)

(patient/insured signature)

(witness)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Patient: Amy R. Smith
3477 Mayberry Road
Columbus OH 79199
218-38-2003

I, Amy R. Smith, in connection with the medical services that I am receiving from Western Street Clinic, do hereby authorize and consent to the production and use of photographs or other electronic records made of me or parts of my body, under the following conditions:

1. The photographs or other electronic recordings may be taken only with the consent and approval of my physician.
2. The photographs or other electronic recordings shall be taken by my physician or by a photographer approved by my physician.
3. The photographs or other electronic recordings shall be used only in support of or in conjunction with a law suit being pursued by me.

Further said photographs or other electronic recordings shall be done only at the request of or with the cooperation of my attorney.

(patient/insured signature)

(date)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Leatrice A. Scott

Dear Leatrice,

Let us be among the first to wish you a very HAPPY BIRTHDAY on April 1. We hope the coming year is a healthy and happy one.

Please come and see us whenever you need our services. We wish you many happy and healthy birthdays in the future.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Cheree Y. Jones
9956 Norton Rd
Galloway OH 79199

Dear Cheree,

Let us be among the first to wish you a very HAPPY BIRTHDAY on April 1. We hope the coming year is a healthy and happy one.

Please come and see us whenever you need our services. We wish you many happy and healthy birthdays in the future.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Stacey L. Sietsma
3810 Brookwood Rd
Columbus OH 79199

Dear Stacey,

As you are nearing the completion of your health care, I wanted to sincerely thank you for being such a great patient. Your restoration back to good health and our relationship have been a true joy to me.

To watch a patient reach the completion of a successful corrective program is the ultimate satisfaction a physician can possibly have.

I am confident that you will continue to follow through with the home care program that we designed for you. One purpose of the home care program that was established is to teach you how to take care of your health. Illness and disease don't just happen ... they accumulate. Therefore, home care, a proper diet, exercise, and needed medical care should always follow your original series of treatment.

Stacey, it has been a pleasure to have you as our patient. You've worked hard to restore your good health, and we congratulate you for that. Protect that investment. Please feel free to call with any difficulties.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Alieha L. Moorer
821 N Drexel Ave
Columbus OH 79199

Dear Alieha,

Because you have consistently failed to keep your scheduled appointments, I find it necessary to inform you that I am withdrawing from further professional attendance to you.

Since your condition requires medical attention, I suggest that you place yourself under the care of another doctor without delay.

If you so desire, I shall be available to attend to you for a reasonable time after you have received this letter, but in no event for more than ninety (90) days. This should give you plenty of time to select a doctor of your choice from the many qualified physicians in this area.

With your written approval, we will make available to this doctor your case history and information regarding the diagnosis and treatment.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Alieha L. Moorer
821 N Drexel Ave
Columbus OH 79199

Dear Alieha,

This is a reminder to let you know your balance of \$48.58 is past due. If you cannot pay this amount in full, we will accept monthly payments until the balance is paid. Thank you in advance for your prompt attention to this bill.

Please make checks payable to: Western Street Clinic

If payment has already been sent, please disregard this notice with our apologies.

Sincerely,

Account Collections



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Patient: Amy R. Smith
3477 Mayberry Road
Columbus OH 79199

I authorize Western Street Clinic and such assistants as the doctor may designate, to perform on Amy R. Smith the following diagnostic procedure:

CAT Scan

The nature of this procedure, possible alternative methods of diagnosis, and the risks of injury despite precautions have been explained to me.

(signature of patient or person authorized to sign for patient)

(date)

(relationship to patient of person authorized to consent)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Patient: Stacey L. Sietsma
3810 Brookwood Rd
Columbus OH 79199
614 555-0714

Responsible Party's Name: Mary Sietsma

Consent to Treat a Minor

The undersigned hereby requests and authorizes Western Street Clinic to perform diagnostic tests and render treatment to Stacey L. Sietsma, a minor child.

This authorization extends to all other clinics, doctors, and office staff members and is intended to include radiographic examination at the doctor's discretion.

As of the date below, the undersigned states and avows to have the legal right to select and authorize health care services for the minor child named above.

If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize this care should be revoked or modified in any way, the undersigned does hereby agree to notify the Western Street Clinic as soon as is possible.

(signature of person authorized to sign for patient)

(date)

(printed name)

(relationship to patient of person authorized to consent)

(witness)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Patient: Amy R. Smith
3477 Mayberry Road
Columbus OH 79199
218-38-2003

Consent to X-Ray

I, Amy R. Smith, do hereby authorize a diagnostic x-ray examination which Joseph E. Martin, M.D. may consider necessary or advisable in the course of examination or treatment.

(patient/insured signature)

(date)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Stacey L. Sietsma
3810 Brookwood Rd
Columbus OH 79199

Dear Stacey,

I feel that it is important to let you know that it truly was a pleasure to have you visit my office recently for consultation and treatment. I sincerely appreciate the confidence you have shown in choosing me as your physician.

As an experienced physician, I have discovered that the patients who benefit the most from health care are those who understand the importance of their roles in the recovery process. By keeping your scheduled appointments and following the instructions that we have discussed, I am confident you will realize the benefits of good health care.

My goal is not only to relieve the symptoms, but to also eliminate the cause of the ailment. I know that with your cooperation we can achieve great results, and you will find yourself living a healthier and happier life.

If you have any questions, do not hesitate to call us. Again, welcome to Western Street Clinic.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Fax Transmission Regulations

1. Objective:

To prevent improper disclosure of patient information and to protect patient confidentiality.

2. Regulations:

- a) Patient information must not be transmitted electronically including by facsimile (FAX) unless the medical information is urgently needed to provide treatment to the patient.
- b) Transmitting of patient information via FAX is limited to circumstances when mail delivery would prevent the information being used by or for the patient in a timely fashion.
- c) FAX transmittals may not be used for routine insurance, attorney, or third party requests that can be effectively handled via U.S. mail or courier services.
- d) Patient information must not be transmitted to receiving Fax machines placed in common areas, such as a library, mail room, or reception area.
- e) The receiving FAX number must be confirmed before transmitting the information.
- f) A confirmation of the receipt of the FAX transmission must always be requested.
- g) In the event that a misdirected FAX is received, immediately notify the sender of the transmission error and ask for instructions. Normally, FAXed material should be returned to the sender via the mail.
- h) Misdirected FAX incidents must be charted and reported to the office supervisor.

Staff Fax Transmission Agreement

I understand and agree with the above mentioned objective and the regulations regarding faxing patient health records or information.

I agree to report any misdirected transmissions, to chart and record all errors and to bring these errors to my supervisor's attention.

Furthermore, I understand the need to comply with this employment's stated regulations regarding patient confidentiality in the office, on a computer system, via mail, telephone or fax transmissions.

(name - please print)

(date)

(signature)



Western Street Clinic
5809 S. Western
Amarillo

Financial Responsibility Statement

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill.

Primary Insurance _____ Effective Date _____

Address _____ City/State/Zip _____

Policy # _____ Group # _____ Phone # _____

Insured _____ Relationship to Insured _____

Secondary Company _____ Effective Date _____

Address _____ City/State/Zip _____

Policy # _____ Group # _____ Phone # _____

Insured _____ Relationship to Insured _____

Medicare Patients

I request that payment of authorized Medicare benefits be made to me or on my behalf to Western Street Clinic for any services furnished me by Joseph E. Martin, M.D.. I authorize that any holder of medical records about me to release to the Health Care Financing Administration and its agents any information necessary to determine benefits and process the insurance claim. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

Non-Medicare Patients

I authorize the release of all medical records needed to process this claim and that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, to Western Street Clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I ASSUME FINANCIAL RESPONSIBILITY FOR ALL CHARGES. I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND IT.

Patient: Amy R. Smith

(If patient is a minor, a parent's signature is required)

(responsible party)

(witness)

(date)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Stacey L. Sietsma
3810 Brookwood Rd
Columbus OH 79199

Dear Stacey,

We value our association with you and the repeated referrals that you make to us. Even if we have not sent a letter of appreciation for your referral, we do value the faith that you place in our abilities and services.

Thank you again.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Patient: Alieha L. Moorer
821 N Drexel Ave
Columbus OH 79199
646-24-3172

Phone: 614 555-4667

Insurance Assignment

In consideration of services to be rendered, I hereby assign and transfer to Western Street Clinic any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage, to include major medical or P.I.P. for the payment of such services rendered. I agree to cooperate, aid and assist Western Street Clinic in procuring all possible insurance benefits including initiation and fulfillment of all policy provisions such insurance companies may require for payment.

I further assign and transfer to Western Street Clinic an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of treatment. This assignment includes insurance benefits occurring to me under uninsured motorist coverage.

If a Medicare patient, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized benefits be made in by behalf.

(patient/insured signature)

(date)

Last Appointment Report

Days Since Last Appointment : 90

Doctor Range: 11-GM - Marti

Code	Patient	Phone	Last Appointment
010117A	Mary M. Abacore 101 Anywhere Amarillo TX 79109	806 655-4545 806 558-6556	4/8/2005
010174	Harold J. Abbot		12/29/2005
21	William DeFoe 8201 Hines Way Amarillo TX 78974		8/28/2003
010142	Johnny Goode 4848 Bonham Amarillo TX 79108	806 463-8898 806 373-8823	12/12/2003
UB031	Jerri J. Hale 2000 Crockett Amarillo TX 79110	806 370-1589 806 325-8875	10/14/2004
010066	Rebecca Hall 4500 N Main Street Amarillo TX 79109	806 555-4545 806 555-1647	5/30/2002
010068	Harry Hamlin 456 N Hollywood Rd Amarillo TX 79109	806 555-2222 806 555-2585	10/21/2005
C3	Frankie Hammer 405 S Frankford Blvd Amarillo TX 79109	806 555-1212 806 555-1313	5/1/2002

Code	Patient	Phone	Last Appointment
010059	James E. Harper 107 Ramsey Dr Red Barn TX 79109	806 555-1212 806 555-1313	9/30/1999
MG	Dud Mackleroy 123 South Western	806 463-7007 800 874-5983	1/13/2005
20	Kelly Raymond 8291 N Billings Amarillo TX 79109		10/9/2002
010118	Janie Zimmerman 778 Grayson Blvd Amarillo TX 79109	806 374-1212 806 467-8852	8/16/2004



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Amy R. Smith
3477 Mayberry Road
Columbus OH 79199

Dear Amy,

I am writing to you to emphasize the importance of following the treatment plan established for you.

Although I have treated you, at your request, for the condition you complained of, you have not complied with the treatment plan that I recommended and that you agreed to. Unless you give me your full cooperation and immediately agree to follow the prescribed treatment, I cannot be responsible for any conditions caused by your noncompliance to the treatment plan.

Kindly contact this office at your earliest convenience to inform me whether you have followed my advice and want to continue treatment.

Sincerely,

Joseph E. Martin, M.D.



April 11, 2006

Patient Confidentiality Office Policy

I. Objective:

To provide a control for the maintenance and release of patient health information.

II. Policy:

The health record is the property of **Western Street Clinic** and shall be maintained to serve the patient, the health care carrier and **Western Street Clinic** in accordance with legal, accrediting and regulatory agency requirements. The information contained in the health record belongs to the patient, and the patient is entitled to the protected right of his/her information. All patient care information will be regarded as confidential and available only to authorized users.

III. Data Collection:

All individuals engaged in the collection, handling or disclosure of the patient health information shall be specifically informed of their responsibility to protect patient data and of the penalty for violation of this trust. Proven violation of confidentiality of patient information shall be cause of immediate termination of access to further data, with possible termination of any employee-employer relationship without option for rehire.

IV. Storage:

- a) All primary health records, kept on paper shall be housed in physically secure areas. All computerized patient health records are to be accorded to the same high level of confidentiality given to manually kept records and all policies herein stated apply to computerized patient health records as well as manually kept records.
- b) Primary health records (from this office) and secondary health records (records obtained from another physician) shall be retained according to legal, accrediting and regulatory agency requirements.
- c) Original health records may not be removed from the premises, except under a court order, request of the physician, or to be stored in an outside storage unit.
- d) Access to areas housing health information records shall be controlled by the Office Manager with the exception of the physician.
- e) Health care records shall not be left unattended in areas accessible to unauthorized individuals.

V. Access:

- a) All requests for health records shall be directed to the Office Manager. Authorization for access to patient information is based on the need to know in order to provide health care and related services required by the patient. All employees shall maintain patient information in the strictest confidence, sharing it only with others who have a need to know in order to provide services to the patient. They shall guard against inadvertent release of information by avoiding the discussion of patient information in public areas.
- b) Release of information from the health record shall be carried out in accordance with all applicable legal, accrediting and regulatory agency requirements, and in accordance with written institutional policy.



Western Street Clinic
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- c) Direct access to patient health records for routine administrative functions, including billing, shall not be permitted, except where the employees are instructed in policies on confidentiality and subject to penalties arising from violation of these specified in IIIa.
- d) All information contained in the health record is confidential and the release of information will be closely controlled. Medical records shall be released when:
 - 1. it is required by law
 - 2. for release to another health care provider currently involved in the care of the patient
 - 3. for medical care evaluation
 - 4. for research and education
 - 5. for accreditation surveys
- e) Health records shall be made available for research to individuals who have obtained approval for their research from the appropriate staff. Data compiled as part of research studies may not include patient identity or other information which could identify the patient unless prior authorization has been obtained.

Staff Confidentiality Agreement

I understand and agree that, as I have access to the clinical and other information about patients and doctors, I must access and use the data only to the extent required by those duties assigned to me.

I further understand and agree that I must hold as confidential all information learned from the computer system, the patient's medical record, or over the course of my work here concerning patients, physicians, employees or the confidential business of this facility.

(name - please print)

(date)

(signature)



Western Street Clinic
5809 S. Western
Amarillo

Registration

Patient Information

_____		_____	
(First, Middle, Last Name)		(Date of Birth)	
_____		_____	
(Address)		(City, State, Zip Code)	
_____	_____	_____	
(Home Telephone Number)	(Work Telephone Number)	(Social Security Number)	
_____		_____	
(Nickname)		(Prior Name)	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Employment Status: <input type="checkbox"/> Employed <input type="checkbox"/> Part-time Student <input type="checkbox"/> Full-time Student <input type="checkbox"/> Other			

Employment Information

_____		_____
(Occupation)		(Employer)
_____		_____
(Address)		(City, State, Zip)

Spouse Information

_____		_____
(Name)		(Date of Birth)
_____		_____
(Social Security Number)	(Occupation)	
_____		_____
(Employer)		(Employer Phone Number)

Responsible Person (If Applicable)

_____		_____	_____
(Name)		(Date of Birth)	(Relationship to Patient)
_____		_____	
(Address)		(City, State, Zip Code)	
_____	_____	_____	
(Phone Number)	(Social Security Number)	(Occupation)	
_____		_____	
(Employer)		(Employer Phone Number)	

Relative to Contact in Case of Emergency (Not Living in Home of Patient)

(Name)

(Phone Number)

(Relationship to Patient)

(Address)

(City, State, Zip Code)

Insurance Information

(Name of Insured)

(Date of Birth)

(Relationship to Patient)

(Insurance Company)

(Group Number)

(ID Number)

(Address)

(City, State, Zip Code)

How were you referred to our office?

- By an Attorney
- By a Doctor
- By a Patient
- Other

Please print the name of your source below.

Is your illness or injury related to any of the following?

- Employment
- Emergency
- Accident
- Auto Accident

If Auto Accident, please print the state where the accident occurred below

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment.

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services not covered by my insurance company.

I certify that I have read this form and understand its contents.

(Patient or Other Legally Authorized Person)

(Date)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Patient: Stacey L. Sietsma
3810 Brookwood Rd
Columbus OH 79199
613-72-6221

Phone: 614 555-0714

Pregnancy Warning and Consent for X-Ray

I, Stacey L. Sietsma, hereby certify that to the best of my knowledge I am not pregnant and that Joseph E. Martin, M.D. or the doctor's associates have my permission to perform a diagnostic x-ray examination. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual period: _____

(patient's signature)

(date)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Stacey L. Sietsma
3810 Brookwood Rd
Columbus OH 79199

Dear Stacey,

This is notification that you are being released from our care for injuries sustained in your accident. We will forward a final itemized bill to the insurance company requesting that payment be made directly to our office.

Please check with our office prior to signing any release papers, to make certain the charges have been satisfied.

If you have any questions, please feel free to contact our office.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Provider: Joseph E. Martin, M.D.
Western Street Clinic
5809 S. Western
Amarillo

Patient: Alieha L. Moorer
821 N Drexel Ave
Columbus OH 79199

Authorization for Medical Information Release and Payment

I hereby authorize the release of any medical or other information for Alieha L. Moorer that is necessary to process her claim.

I also request payment of government benefits either to me or to the party who accepts assignment.

I also authorize payment of medical benefits to the above provider for any services.

This information also permits the release of information to this provider by HCFA, its intermediaries, or carriers on any unassigned Medicare claims.

I further permit copies of this authorization to be used in place of the original Term of Authorization.

Executed from _____ until _____
(date) (date)

(patient/insured signature)

(date)



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Alieha L. Moorer
821 N Drexel Ave
Columbus OH 79199

Dear Alieha,

It has come to our attention that you have been reimbursed by your insurance company for your visit with Joseph E. Martin, M.D.. Please sign the check over to Joseph E. Martin, M.D. and bring it into the office. If you have already cashed the check, please write another one to Joseph E. Martin, M.D..

Thank you for your promptness.

Sincerely,

Account Collections



Western Street Clinic
5809 S. Western
Amarillo

Sign-In Sheet

Tuesday, April 11, 2006

	Patient Name	Address Change Since Last Visit?	Telephone # Change Since Last Visit?	Insurance Change Since Last Visit?	
1		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
2		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
3		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
4		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
5		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
6		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
7		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
8		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
9		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
10		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
11		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
12		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
13		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
14		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
15		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
16		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
17		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
18		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
19		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
20		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
21		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
22		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
23		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
24		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
25		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
26		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
27		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
28		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
29		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
30		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
31		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
32		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
33		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
34		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
35		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Alieha L. Moorer
821 N Drexel Ave
Columbus OH 79199

Dear Alieha,

My staff and I would like to extend a warm thanks for again selecting us for your medical care. We sincerely hope that your visit with us was pleasant as well as beneficial for your specific problem.

Should any questions come to mind regarding your treatment, the nature of your problem, fees, insurance, or anything else concerning your care, please feel free to ask.

Our goal is to provide you with the best possible care.

Sincerely,

Joseph E. Martin, M.D.



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Nationwide financial
OH

Dear Sir,

Your employee, Stacey L. Sietsma, has reported to our office for examination and treatment due to injuries sustained while on the job. Please sign and return this authorization for treatment to our office and submit a copy of the completed Employee's Injury Report. Thank you for your assistance.

Sincerely,

Joseph E. Martin, M.D.

Employer's Worker's Compensation Authorization

Employee: _____ Date of accident: _____

Insurance Carrier: _____

Adjuster/Agent: _____

Supervisor: _____

(signature)

(title)

Pre-authorized by phone: _____ by: _____
(date)

Specific Instructions: _____



Western Street Clinic
5809 S. Western
Amarillo

April 11, 2006

Alieha L. Moorer
821 N Drexel Ave
Columbus OH 79199

Dear Alieha,

Since you have recently suffered a work-related injury, we would like to clarify how our office will handle your case. First, you need to know that your employer's insurance carrier is financially responsible only for treatment of your physical condition that is a result of your employment-related incident. Your worker's compensation insurance will pay for treatment that restores your health to a pre-injury status, or permanent and stationary condition.

You may be experiencing symptoms or problems that you suffered prior to your injury which may be contributing to your symptoms, therefore a judgment will be made as to what extent these factors have on your present injury. Your worker's compensation insurance carrier will be advised as to the significance of these factors, if any.

It is imperative that you follow my medical suggestions and keep your scheduled appointments. If you choose not to receive the care that is necessary for your injury, your Worker's Compensation may discontinue your benefits and close your case immediately.

When your condition has reached pre-injury status, or is determined to be permanent and stationary, we will notify you as well as your workers' compensation insurance carrier.

We thank you for the opportunity to serve you and welcome any questions that you may have concerning your case.

Sincerely,

Joseph E. Martin, M.D.